

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

1. PLACE OF DEATH

County.....

Registration District No.....

Township.....

Primary Registration District No.....

City.....

City. Infirmary.

St. Ward)

2. FULL NAME.....

(a) Residence, No.....
(Usual place of abode)

Length of residence in city or town where death occurred

55 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male.

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

Minnie B. Weir

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

3/3/1861

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1
day, hrs.
or min.

13

4

9

OCCUPATION

8. Trade, profession, or particular
kind of work done, as spinner,
sawyer, bookkeeper, etc.9. Industry or business in which
work was done, as silk mill,
saw mill, bank, etc.10. Date deceased last worked at
this occupation (month and
year)11. Total time (years)
spent in this
occupation

Laborer

12. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

13. NAME

14. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)17. INFORMANT
(ADDRESS)18. BURIAL, CREMATION, OR REMOVAL
PLACE19. UNDERTAKER
(ADDRESS)

20. FILED

3 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR)

7-12-1934

22. I HEREBY CERTIFY, That I attended deceased from

5-15-1929, to 7-12-1934

I last saw him alive on 7-12-1934. Death is said

to have occurred on the date stated above, at 3:00 P.M.

The principal cause of death and related causes of importance were as follows:

Chronic myocarditis

936

99

1098

Other contributory causes of importance:

arteriosclerosis

Hypertension

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide?..... Date of injury..... 19.....

Where did injury occur?.....

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify.....

(Signed) Maxine L. Hawn, M. D.

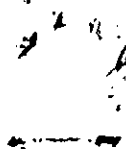
(Address) 5600 Arsenal St.

Registrar.

26705

File No. 6886

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